Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 20, 2017	2017_582548_0013	000491-17, 000492-17, 006996-17	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

Long-Term Care Home/Foyer de soins de longue durée

CARLETON LODGE
55 LODGE ROAD R. R. #2 NEPEAN ON K2C 3H1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 19 and 20, 2017

related to three separate medication incidents

During the course of the inspection, the inspector(s) spoke with Program of resident care, Registered nurse, Registered practical nurses and Personal support worker

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The Licensee failed to inform the Director of missing or unaccounted controlled substances no later than one business day after the occurrence of the incident.

A critical incident report was submitted to the Director on specified date under the Long-Term Care Homes Act (LTCHA), 2007, related to a controlled substance that was missing or unaccounted for. On a specified day in a count was conducted by two registered nursing staff, the total number of capsules remaining for a controlled substance was recorded as 2 on resident's #001 Narcotic and Controlled Drug Administration Record. The next day at a specified time a discrepancy of one tablet was noted. Two registered nursing staff who completed the narcotic and controlled substance count recorded that there was one remaining tablet remaining instead of two.

Review of resident's #001 Medication Administration Record (MAR), it was recorded during a specified month that the resident was to have the controlled substance administered at a specific time on a daily basis.

The medication incident was reported to both program managers via email correspondence on a specified day by a registered nurse.

On July 19, 2017 during an interview with the inspector #548 the Program manager of resident care indicated that she became aware of the incident upon her return back from holidays. She indicated that although the both program managers were informed by email correspondence the Program manager of personal care had missed the email.

From the review of resident's #001 Narcotic and Controlled Drug Administration Record for a specified period of time it was noted that the overall count was correct with the exception of two subsequent days. There was no record that the drug was accounted for on those two days however, the number of tablets decreased by two.

The Licensee failed to inform the Director of missing or unaccounted controlled substances, as required. [s. 107. (3)]

Issued on this 21st day of July, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.